



SUBSTANCE USE DISORDER PRE-ADMISSION SCREEN - INTENSIVE INPATIENT TREATMENT

If offender has arson convictions, wants, warrants or detainers, do not complete this form.

Date: _____

Offender Name: _____

DOC #: _____ DOB: _____ Age: _____ Male Female

Residence: _____

City: _____ County of Residence: _____

Offender Phone Number(s): _____

Current Location: _____

Emergency Contact (Must be Next of Kin): _____

Address: _____

Emergency Contact Phone Number(s): _____

Supervising CCO: _____ Phone Number: _____

Referring CCO: _____ Phone Number: _____

Assigned Field Office: _____

Describe transportation arrangements necessary to transport offender to the facility:

Date offender will be available to enter treatment: _____

Legal

Is the offender currently under supervision as a result of a residential DOSA sentence? Yes No

Current Conviction(s) _____

Assault Convictions (Past and Present)? Yes No

Nature of Assault Convictions and Dates (please provide specific details of crime)

Contact Restrictions/Victim concerns _____

If any sex Offense Crimes in history, is registration Required? Yes No

Level _____

Nature of Sex Offense Convictions and Dates (please provide details of crime to include relationship to victim, age of victim, circumstances around crime and if the offender has more than one crime of this nature)

Does offender have any documented Security Threat Group (Gang) Affiliation? Yes No

If so, what? _____

Alcohol/Drug Use and Treatment

When did offender last use/drink? _____

List history of all drug(s) or alcohol used _____

Any history of withdrawal? Yes No Unknown

Detox Needed? Yes No

Has offender been to SA treatment Before? Yes No

Provider Name	Dates	Type	Completed
		<input type="checkbox"/> TC <input type="checkbox"/> IIP <input type="checkbox"/> IOP <input type="checkbox"/> OP	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> TC <input type="checkbox"/> IIP <input type="checkbox"/> IOP <input type="checkbox"/> OP	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> TC <input type="checkbox"/> IIP <input type="checkbox"/> IOP <input type="checkbox"/> OP	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> TC <input type="checkbox"/> IIP <input type="checkbox"/> IOP <input type="checkbox"/> OP	<input type="checkbox"/> Yes <input type="checkbox"/> No

TC: Therapeutic Community IIP: Intensive Inpatient IOP: Intensive Outpatient OP: Outpatient

Is offender willing to participate in treatment? Yes No

Does offender have any special needs or limitations? (e.g., mobility, literacy, language, dietary) Yes No

If yes, what are they? _____

Medical

When does offender report last visit to a medical provider? _____

What was the purpose of the visit? _____

Does offender report that s/he is under the care of a medical provider? Yes No

Reason(s):

Does offender have any open wounds that are not healing? Yes No

Does offender report she is pregnant? Yes No Trimester: 1st 2nd 3rd

Does the offender report any significant physical/medical conditions (treated/untreated) that would interfere with full participation in treatment? Yes No

If yes, what? _____

Does the offender report taking prescribed medications for any condition(s) noted above? Yes No

If yes, list medication(s) _____

If yes, will offender be able to bring a 30-day supply of the prescribed medication(s) with him/her to treatment? Yes No

Significant medical issues past or current that may preclude offender from fully participation in Intensive Inpatient SA Treatment?

Psychological

Does offender report any significant emotional/mental health conditions? Yes No

Has the offender been engaged in treatment for any such conditions?

Inpatient: Yes No Outpatient: Yes No

Please describe:

Does offender report having any recent suicide ideations Yes No

Does offender report having any past suicide attempts Yes No

Has a psychological evaluation been completed? Yes No

If yes, what is the diagnosis? _____

Does offender take any prescribed medications for the condition(s)? Yes No

If yes, list medication(s) _____

If yes, will offender be able to bring 30-day supply of the prescribed medication(s) with him/her to treatment? Yes No

NOTE: 1. THE OFFENDER MUST HAVE A 30-DAY SUPPLY AT TIME OF ADMISSION OR THEY WILL NOT BE ALLOWED TO ENTER INPATIENT TREATMENT.

2. THE OFFENDER WILL NOT BE ALLOWED TO USE THE FOLLOWING MEDICATIONS, AND WILL BE DETOXED WHILE IN TREATMENT:

- barbiturates
- narcotic-opiates
- norepinephrine
- opiate maintenance medication
- stimulants
- benzodiazepines
- medical cannabis
- methadone
- health food supplements
- any item containing alcohol

Significant mental health issues past or current that may preclude offender from fully participating in Intensive Inpatient SA treatment?

Housing and Continuing Care

Does offender have an approved release address? Yes No

Provide Address: _____

*** Treatment provider will make arrangements for outpatient care and schedule the appointment for the offender.**

CC: Supervising CCO

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